Received & Harthacks PRINTED: 07/22/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES > FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G193 07/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 74 'W' ST, NW **WESTVIEW 02** WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY {W 000} INITIAL COMMENTS {W 000} Another follow-up survey was conducted on All individuals that resided at 74 W Street have 7/13/10 - 7/15/10 to verify that the facility had moved to other facilities. One of the individuals come into compliance with deficiencies identified chose another agency. Two individuals moved in the previous follow-up survey on 6/10/10. The to an ICF. Two other individuals moved to a governing body submitted a Plan of Correction wavier facility. It is the intent of the administradated 7/12/10. tion of MarJul Homes, Inc. to see that any and all deficiencies cited on the individuals residing The follow-up visit revealed that there had been in our homes are being addressed. significant progress made since the 6/10/10 follow-up survey. Through observation. interviews with staff and residents and review of The administration recognizes the important role the consultants plays in ensuring the records, the determination was made that the quality of life for the indivudauls we serve. facility was in substantial compliance with the Conditions of Participation of Governing Body, in an effort to ensure the hightest quality, Client Protections and Health Care Services. all consultant contracts are under review. However, there remained some standard level Some contracts will be terminated due to deficiencies, as evidenced in the report that not honoring thier commitments. New follows. consultants will be hired where needed. We {W 159} 483.430(a) QUALIFIED MENTAL have also met with the DCHRP and they {W 159} RETARDATION PROFESSIONAL have offered thier assistance and support. We will be taking advantage of this offer. Each client's active treatment program must be See attachment. integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure the qualified

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 program participation.

mental retardation professional (QMRP)

(Clients #1, #2, #3, #4 and #5)

The findings include:

coordinated, integrated, and monitored services, for five of the five clients residing in the facility.

1. [Cross-refer to W189 and W249] The QMRP

failed to ensure that all direct support staff

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

support plans.

1.In each facility systems are being put in

TITLE

place to ensure that staff receive training on

consistent implementation of client's behavior

8/11/2010

(X6) DATE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		09G193	B. WIN			1	₹ 5/2010
NAME OF P	ROVIDER OR SUPPLIER EW 02			7	REET ADDRESS, CITY, STATE, ZIP CODE 4 W ST, NW VASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLO BE	(X5) COMPLETION DATE
{W 159}	received training or clients' behavior su QMRP, all five clier 2. [Cross-refer to W failed to ensure that received training or documentation of b 3. [Cross-refer to W ensure that direct sassigned to meal p effectively trained or prescribed high fibe 4. There was no extended to the composition of the composition o	reconsistent implementation of poort plans. According to the poort plans. According to the poort plans. According to the plans had behavior support plans. It is and W252] The QMRP to all direct support staff to consistent and accurate ehavioral incidents. In the QMRP failed to upport staff who were reparation duties were in provision of Client #3's er diet. Indence that the QMRP had nutritionist's recommendation a speech-language screening (13/10, interview with the by telephone revealed that the ered into a contract/agreement uage therapist on the day the further indicated that to not received a creening. This was verified then #3's record on 7/14/10.	{W 1	59)	2. The QMRP, and subject to the re Quality Assurance Specialist, will er all direct care staff receive training of consistent and accurate documental behavioral incidents. 3. The QMRP, and subject to the re Quality Assurance Specialist, will er direct support staff are effectively trathe prescribed diets of all individuals. 4. The contract for the speech-languiconsultant has been signed. An assiby the consultant for Client # 3 is sold See attachment.	nsure that on view by the nsure that ained on s. lage essment	8/18/2010 8/18/2010
	Previously, the 6/10 the following:	0/10 deficiency report included					
	[Cross-refer to Walled to ensure that training on consisted documentation of bases.]				See W 159 #2		8/18/2010

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU		IG	(X3) DATE S COMPLE	ETED
		09G193	B. Wil	NG_			R 5/2010
NAME OF P	PROVIDER OR SUPPLIER			7	REET ADDRESS, CITY, STATE, ZIP CODE 4 W ST, NW VASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT DF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{W 159}	Continued From pa	age 2	{W 1	59}			
	evidence that the Conutritionist's recomma speech-language Citation W460 in the dated 5/3/10, incluinthe <nutritionist's 'having="" (speech="" 4="" and="" difficultionistency.="" in<="" individual="" long="" slp="" swable="" td="" time="" to="" tolerate="" very="" was=""><td>W460.2] There was no QMRP had followed-up on the imendation (4/29/10) to obtain a screening for Client #3. The federal deficiency report ded the following: "According to 1/29/10> assessment, the client the swallowing regular dual holds food in mouth, takes wallowing. Individual will be nechanical soft diet. Will notify anguage) for screening.' At the however, the SLP screening duled."</td><td></td><td></td><td>See W 159 #4</td><td></td><td>8/18/2010</td></nutritionist's>	W460.2] There was no QMRP had followed-up on the imendation (4/29/10) to obtain a screening for Client #3. The federal deficiency report ded the following: "According to 1/29/10> assessment, the client the swallowing regular dual holds food in mouth, takes wallowing. Individual will be nechanical soft diet. Will notify anguage) for screening.' At the however, the SLP screening duled."			See W 159 #4		8/18/2010
	with the QMRP revice contacted the special since she began so 5/14/10. She indictive director planned to appointments. She "has to come. We	eximately 3:15 p.m., interview realed that she had not ech-language therapist (SLP) erving as the QMRP on ated that the facility's executive call the SLP to schedule e further indicated that the SLP 're going to get everyone an fithem are putdated."					
	support staff was of chopping food with stated that she and Client #3's foods to However, review of failed to show evid PCP had been mater recommendations SLP screening. Of following dietary of	oximately 5:10 p.m., a direct observed in the kitchen, a knife. When asked, she diother staff always chopped to help his swallowing. If the client's physician's orders ence that the recently-assigned de aware of the previous for altered food texture and an in 5/19/10, the PCP wrote the ders: "Regular, Double er snacks. Prune juice 1 cup					

	F CORRECTION	IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		09G193	B. WI	1G _			₹ \$/2010
NAME OF P	ROVIDER OR SUPPLIER			74	REET ADDRESS, CITY, STATE, ZIP CODE 4 W ST, NW VASHINGTON, DC 20015	1 0//13	X2010
(X4) iD PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
(W 159)	nutritionist wrote " complete nutrition mechanical soft te ground diet <cli]="" a="" de<="" ground="" is="" repeat="" td="" texture."="" this=""><td>that on 6/2/10, a new Client #3> was assessed for a evaluationThe current diet of ature is synonymous to a ent #3> should receive a ficiency.</td><td>(₩ 1</td><td>59}</td><td></td><td></td><td></td></cli>	that on 6/2/10, a new Client #3> was assessed for a evaluationThe current diet of ature is synonymous to a ent #3> should receive a ficiency.	(₩ 1	59}			
(W 189)	dpcumentation of program Plan (IPF #4. [See W252] 2. The facility's QN services to ensure necessary to provi #3. [See W460] 483.430(e)(1) STA The facility must p initial and continuir employee to perform efficiently, and continuir employee to perform the standard continuity and continuity efficiently, and continuity efficiently the facility effectively trained to behavior support performance in the standard continuity effectively trained to behavior support performance in the standard continuity effectively trained to behavior support performance in the standard continuity effectively trained to behavior support performance in the standard continuity effectively trained to behavior support performance in the standard continuity effectively trained to behavior support performance in the standard continuity effectively trained to behavior support performance in the standard continuity effectively trained to behavior support performance in the standard continuity effectively trained to behavior support performance in the standard continuity effectively trained to behavior support performance in the standard continuity effectively trained to behavior support performance in the standard continuity effectively trained to behavior support performance in the standard continuity effectively effectively trained to behavior support performance in the standard continuity effectively eff	ARP failed to ensure consistent progress on the Individual provide as de the prescribed diet of Client are TRAINING PROGRAM provide each employee with any training that enables the form his or her duties effectively, inpetently. Is not met as evidenced by: tion, staff interview and record failed to ensure staff was on implementing clients' plans and documenting targeted priors in the clients' behavior	{ ₩ 1	89}	1 a. The QMRP will train the direct of consistent documentation on the Incorporation Program Plan, subject to the review Quality Assurance Specialist. 2 a We are in the process of securing services of a new nutritionist who wall individual diets and ensure that and management staff are trained of effective implementation of the presonal individuals. The management required to observe the preparation implementation of the prescribed diet.	ng the right assess all DSP's on the scribed diets staff will be	8/18/2010

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
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NAME OF P	ROVIDER OR SUPPLIER			74	EET ADDRESS, CITY, STATE, ZIP CODE W ST, NW VASHINGTON, DC 20015	<u>, </u>	5/20 0
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{W 189}	data, for 6 of the 13 facility. The findings include	3 direct support staff in the	{VV 1	89}			
	at 5:45 p.m., Client the living room with unbuttoned and un exposed. Initially, However, a direct speaking with him The staff did not er	V249 and W252] On 7/14/10, it #3 was observed standing in mout a shirt. His jeans were izipped. His boxer briefs were the client was standing alone, support staff person began from the nearby dining room, incourage him to button up eans while they conversed.			See W 159 # 2		8/18/2010
	behavior data form documented the 5: previous evening a behavior support p Moments later, at a retardation profess direct him to zip his staff would do it fol however, been obs	p.m., review of Client #3's as revealed that staff had not 45 p.m. episode from the as required by Client #3's alan (BSP) dated 4/19/10. 3:40 p.m., the qualified mental sional stated that "staff should as pants up, if he refuses then ar him." The staff had not, served implementing the gies as putlined in the BSP.					
	on clients' program and 7/13/10. Staff were reviewed on of the staff signaturale staff person assist Client #3 wit afternoon, at 5:45 the previous evenievidence that the t	ented having provided training as and data collection on 7/9/10 in-service training records 7/14/10. At 11:55 a.m., review re sheets revealed that the who failed to instruct and/or the zipping his zipper (later that p.m.) had received training on a (7/13/10). There was no raining presented on client a collection had been effective.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
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NAME OF P	ROVIDER OR SUPPLIER			74	EET ADDRESS, CITY, STATE, ZIP CODE 4 'W' ST, NW VASHINGTON, DC 20015		
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{W 189}	7/13/10 signature s direct support staff There was no evident	ege 5 er review of the 7/9/10 and sheets revealed that 7 of the 13 had attended the trainings. ence, however, that the other 6 training on client programs and	{W 1	89}	N/A		
	Previously, the 6/10 the following:	0/10 deficiency report included					
	to remove all of his living room. Revier at 8:55 a.m., revea duty at the time fail on his behavior dar incident was indica 6/6/10; however, it in the program boo	52] On 6/9/10, at a.m., Client #3 was observed clothing while standing in the w of his records the next day, led that the staff who were on ed to document the incident in a sheets. Another behavioral sted in a staff log entry on too had not been documented k, in accordance with the apport plan (BSP), dated					£
{W 192}	with the qualified m (QMRP) revealed to in-service training service training service appointed by a councorroborated a sho direct support staff	eximately 3:15 p.m., interview nental retardation professional hat the facility had not provided since new management was left on 5/14/10. This was left time later (4:05 p.m.) by two who were interviewed.	{ ₩ 1	92}			
!		o work with clients, training s and competencies directed		!			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	P) MULTIPLE CONSTRUCTION BUILDING	(X3) DATE SURVEY COMPLETED
09G193 B.	WING	R 07/15/2010
NAME OF PROVIDER DR SUPPLIER WESTVIEW 02	STREET ADDRESS, CITY, STATE 74 'W' ST, NW WASHINGTON, DC 200'	E, ZIP CODE
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR	REFIX (EACH CORRECTIVE FAG CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIATE DIENCY) (X5) COMPLETION DATE
This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that all staff were effectively trained to implement prescribed diets, for one of the five sampled clients. (Client #3) The finding includes: [Cross-refer to W460] On 7/13/10, at approximately 5:15 p.m., interview with the direct support staff person who was preparing dinner in the kitchen revealed that all 5 clients, including Client #3, had received apple sauce for snack. Moments later, review of a list of "low fiber" foods that was posted on a kitchen bulletin board revealed that apple sauce was among the food items considered "low fiber." There was no comparable list of "high fiber" food items posted in the kitchen. Client #3, who had already finished his apple sauce at the time, had physician's orders that prescribed an "increased fiber" diet. The staff person had prepared stir-fried vegetables with chopped turkey meat, to be served over white rice. When asked about Client #3's prescribed high fiber diet and how the facility ensures that his meals are high in fiber, the staff person indicated that she wasn't sure and then referred this surveyor to two other (male) staff who had been "working here longer." Review of the menu she had used for that evening's meal revealed that it did not address high fiber diet	See W 159 #2a	8/18/2010

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	ULTIPL LDING	E CONSTRUCTION	(X3) DATE SU COMPLE	
		09G193	B. WIN	_			R 5/2010
NAME OF P	ROVIDER OR SUPPLIER			74 '	ET ADDRESS, CITY, STATE, ZIP CODE W'ST, NW ASHINGTON, DC 20015		3/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(XS) COMPLETION DATE
{W 192}	7/14/10. The facilit the nutritionist pres diets. At 1:30 p.m. signature sheet rev who prepared the interviewed) did not Only one of the two mentioned by nam addition, review of 6/14/10 revealed a recommended brown 7/13/10, however, over white rice. This is a repeat de Previously, the 6/1 the following: [Cross-refer to W4 Client #3 was offer snack. The nutrition recommended that items, in part to acconstipation and following the proximately 5:10 previously unawardiber snacks. She received any training choices. She furth list of high fiber snareference. On 6/9	ning records were reviewed on by documented that on 6/14/10, sented training on prescribed, review of the 6/14/10 yealed that the staff person 7/13/10 dinner (and who was at attend the nutrition training, or male co-workers she had he had attended the training. In the training materials used on list of high fiber foods that we rice for increased fiber. On Client #3's stir-fry was served ficiency. 0/10 deficiency report included fice on 6/9/10, at 4:16 p.m., red sugar wafers for afternoon onist, however, had the receive hi-fiber snack ldress recurrent bouts of	{W 1	92}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		LE CONSTRUCTION	(X3) DATE SUP COMPLET	
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NAME OF B	DO MOED OO CUIDDUED	09G193	1	CTD	TET ADDRESS CITY STATE 7/2 CODE	07/15	/2010
WESTVIE	ROVIDER OR SUPPLIER			74	EET ADDRESS, CITY, STATE, ZIP CODE W \$T, NW ASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	iX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPLICATION OF CORRECTIVE ACTION OF	ULD BE	(X5) COMPLETION DATE
{W 192}	in-service training team was appointed	lity had not provided staff since the new management of on 5/14/10. This was also view of training records on	{W 1	92}			
W 249	pointed to annound for mandatory staf was scheduled for	at 2:50 p.m., the QMRP cements posted in the facility, f training by the nutritionist. It 6/14/10.] OGRAM IMPLEMENTATION	w	249			
	formulated a client each client must re treatment program interventions and and frequency to s	erdisciplinary team has its individual program plan, eceive a continuous active in consisting of needed services in sufficient number support the achievement of the ed in the individual program			See W 159 #2		8/18/2010
	Based on observa review, facility sta implement client b	is not met as evidenced by: tion, interview and record ff failed to consistently sehavior support plans, for one ncluded in the sample. (Client					
	The finding includ	es:					
	was observed sta a shirt. His jeans His boxer briefs w was standing alor staff person bega	14/2010, at 5:45 p.m., Client #3 nding in the living room without were unbuttoned and unzipped. rere exposed. Initially, the client is. However, a direct support in speaking with him from the m. The staff did not encourage					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SU COMPLET	
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W 249 {W 252}	they conversed. On 7/14/2010, at 9 behavior support p revealed "Disrobin- the bathroom/bedr challenging malad- the BSP. In an interview with retardation profess 3:40 p.m., she star zip his pants up, if it for him." 483.440(e)(1) PRO Data relative to ac specified in client	age 9 Ind/or zipper his jeans while It 35 a.m., review of Client #3's Ilan (BSP) dated 4/19/10, had Ig" or "removing clothes not in Incom" was one of several Inaptive behaviors identified in In the qualified mental Isional (QMRP) on 7/15/2010, at Ited "staff should direct him to Inhe refuses then staff would do INDOGRAM DOCUMENTATION INDOCUMENTATION INDOCUMENTATIO	W 24			
	Based on observa review, the facility documentation of	is not met as evidenced by: tion, interview and record failed to ensure consistent progress on the Individual) objectives, for one of the five ple. (Client #3)		See W 159 #1a		8/18/2010
	The finding includ	es:				
	was observed sta a shirt. His Jeans His boxer briefs w was standing alor	14/2010 at 5:45 p.m., Client #3 nding in the living room without were unbuttoned and unzipped, were exposed. Initially, the client ie. However, a direct support in speaking with him from the				

TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING		TED			
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NAME DE PI	ROVIDER OR SUPPLIER			74 °\	T ADDRESS, CITY, STATE, ZIP CODE ** ST, NW SHINGTON, DC 20015	COMPLETED R 07/15/2010 CODE ORRECTION ON SHOULD BE IE APPROPRIATE COMPLETED (X5)		
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{W 252}	Continued From p	Continued From page 10		52}				
	nearby dining room him to button up a they conversed.	n. The staff did not encourage nd/or zipper his jeans while						
	behavior support revealed "Disrobing the bathroom/bed challenging malar the BSP. Accord Behavior Form and Sheet, staff shout targeted behavion the aforemention p.m., revealed the 5:45 p.m. episod the ABC Data Colon an interview were tardation profe 3:40 p.m., she staip his pants up, it for him."	ith the qualified mental ssional (QMRP) on 7/15/2010, at ated "staff should direct him to if he refuses then staff would do						
	revealed Client across the room naked next to the immediately interclients back on the other clients Client #3's beha	on 6/9/2010, at 8:06 a.m., 43 removed his shirt, threw it , dropped his pants and stood e sofa. The direct support staff ervened, instructing him to put his , while other staff quickly escorte	d		•			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	COMPLETED R	
09G193	B. WING		1	5/2010
NAME OF PROVIDER OR SUPPLIER WESTVIEW 02	74 W	ADDRESS, CITY, STATE, ZIP CODE ST, NW HINGTON, DC 20015		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX YAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X6) COMPLETION DATE
(6/10/10), beginning at 8:38 a.m. "Disrobing" pr "removing clothes not in the bathroom/bedroom" was one of several challenging maladaptive behaviors identified in the BSP. According to the Frequency of Targeted Behavior Form and the ABC Data Collection Sheet, staff should document each episode of a targeted behavior that was observed. Review of the aforementioned forms on 6/10/10 at approximately 8:45 a.m., revealed that staff had not documented the 8:15 a.m. disrobing episode on the ABC Data Collection Sheet. [Note: Staff had documented another episode of disrobing earlier that morning, at "7:30 a.mjust before breakfast."] 2. On 6/9/10, at approximately 3:30 p.m., review of the Daily Log Book (in which staff documented their activities throughout their shift), revealed the following entry dated 6/6/10, at 6:00 a.m. " <client #3="" #4,="" 10="" 10,="" 3="" 5="" 6="" 8:45="" a="" a.m.,="" abc="" and="" approximately="" as="" at="" behavior="" behavior.="" below:<="" cleaned="" clients="" collection="" consistently="" data="" dated="" deficiency="" deficiency.="" designed="" documentation="" dry="" ensure="" evidenced="" facility="" failed="" federal="" following:="" improve="" included="" is="" left="" maintained="" no="" objectives="" observed="" of="" on="" previously,="" put."="" repeat="" report="" revealed="" review="" sheet="" sofa="" sofa;="" strlpped="" targeted="" td="" that="" the="" there="" this="" to="" totally="" training="" was="" wet=""><td>{W 252}</td><td></td><td></td><td></td></client>	{W 252}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		LE CONSTRUCTION	COMPLET	LED
		09G193	B. WIN	G		07/15	/2010
NAME OF P	ROVIDER OR SUPPLIER			74	ET ACORESS, CITY, STATE, ZIP CODE 'W' ST, NW ASHINGTON, DC 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{W 252}	a. Observation of Capproximately 6:19 talking to herself, at the left side of her behavior support p 4/30/10 at 9:24 a.m. self-injurious behavior support p 4/30/10 at 9:24 a.m. self-injurious behavior of Targ slapping/punching documented. The also required that interventions, and be documented exhibit a targeted aforementioned for revealed that the f surveyor on 4/29/20/2006	Client #4 on 4/29/10, at 0 p.m., revealed she began as she repeatedly hit herself on head Review of Client #4's plan (BSP) dated 8/17/09, on m., revealed the client exhibited viors (SIB), which included an face or head. According to be ted Behavior Form, the face behavior should be a ABC Data Collection Sheet antecedents, behaviors, responses to the intervention ach time staff observe the client behavior. Review of the arms on 4/30/10 at 9:35 a.m., face slapping observed by the 10 during the medication if not been documented.	{W 2	52}			
(W 460)	administration on he slapped himse his face He the loudly, and began was no document Collection Sheet of targeted behavior 483.480(a)(1) FOR SERVICES Each client must well-balanced dieles specially-prescribed the specially-prescribed the special statement of the statement of the special statement of the special statement of the special statement of the statement of the special statement of the statement of	OD AND NUTRITION receive a nourishing, t including modified and		160 }	See W 159 #2a		8/18/2010

PRINTED: 07/22/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 09G193 07/15/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 74 'W' ST. NW **WESTVIEW 02** WASHINGTON, DC 20015 PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES 1D (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY {W 460} {W 460} Continued From page 13 diet was provided as prescribed, for one of the five clients in the sample. (Client #3) The finding includes: On 7/13/10, at approximately 4:50 p.m., Client #1 was observed with a bowl of apple sauce. He indicated that this was his aftempon snack. At approximately 5:15 p.m., interview with the direct support staff person who was preparing dinner in the kitchen revealed that all 5 clients had received apple sauce for snack. Moments later, review of a list of "low fiber" foods that was posted on a kitchen bulleting board revealed that apple sauce was among the food items considered "low fiber." Client #3, who had already finished his apple sauce at the time, had physician's orders that prescribed an "increased fiber" diet. It should be noted that the facility had documented that on 6/14/10, the nutritionist presented training on prescribed diets. Among the materials used at the training was a list of high fiber foods. This is a repeat deficiency.

Previously, the monitoring survey conducted from 4/29/10 to 5/3/10 revealed Client #3 had a history of bowel obstruction and multiple emergency

Observation, interview and record review during the follow-up survey conducted on 6/9/10 and 6/10/10, revealed that the facility failed to ensure Client #3 was provided a modified (high fiber) dist in accordance with his assessed needs. For instance, on 6/9/10, Client #3 and his peers were given sugar wafers for afternoon snack when his

room (ER) visits due to constipation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	ILDING	COMPLI	COMPLETED	
		09G193	B. WING		R 07/15/2010		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 74 'W' ST, NW WASHINGTON, DC 20015				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFI TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE		
{W 460}	Continued From pa physician's orders	age 14 called for high fiber snacks.	{W 4				

Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING HFD03-0202 07/15/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 74 'W' ST. NW **WESTVIEW 02** WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {R 000} (R 000) INITIAL COMMENTS Another follow-up survey was conducted on 7/13/10 - 7/15/10 to verify that the facility had come into compliance with deficiencies identified in the previous follow-up survey on 6/10/10. The governing body submitted a Plan of Correction dated 7/12/10. However, through observation, interviews with staff and residents and review of records, the determination was made that the facility remained not in compliance with 22 DC Municipal Regulations, Chapter 47, Health Care Facility Unlicensed Personnel Criminal Background Checks, as evidenced in the report that follows. {R 125} 4701.5 BACKGROUND CHECK REQUIREMENT {R 125} The administration of MarJul Homes has 8/12/2010 amended the employee handbook and revised The criminal background check shall disclose the the policy and proedure manual to stimplate the criminal history of the prospective employee or following: The criminal background check shall contract worker for the previous seven (7) years. disclose the criminal history of the prospective in all jurisdictions within which the prospective employee or contract worker for the previous employee or contract worker has worked or seven (7) years, in all jurisdictions within which resided within the seven (7) years prior to the the prospective employee or contract worker has check. worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on interview and review of personnel records, the Group Homes for Persons with Mental Retardation (GHMRP) failed to ensure timely criminal background checks for all jurisdictions in which the employees had worked or resided within the 7 years prior to the check. for 5 out of 13 direct support staff whose background check documentation was made available for review. (S1, S2, S3, S4 and S8) The findings include:

Health Regulation Administration

TITLE

(X6) DATE

On 6/10/10, during the Exit meeting, the

Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING HFD03-0202 07/15/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 74 'W' ST. NW **WESTVIEW 02** WASHINGTON, DC 20015 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {R 125} {R 125} Continued From page 1 GHMRP's administrator was informed that there was no evidence of comprehensive criminal background checks for 6 out of 13 direct support staff (#1, #2, #3, #4, #7 and #8). The facility's Plan of Correction, signed by the administrator on 7/12/10, indicated that the checks would be secured on 7/14/2010, more than one month later. On 7/14/10, beginning at 1:30 p.m., review of the six employees' personnel records revealed the following: 1. Nationwide criminal background checks were documented for S1, S2, S3 and S8, all of which were commissioned and secured on the morning of 7/14/10. Review of staff schedules revealed that the four employees had continued to work in the facility between 6/10/10 and 7/14/10. [Note: All 4 of the background checks revealed "no records found."] 2. Staff #7 was no longer employed by the agency. His last day with the facility reportedly was 6/10/10; therefore, no additional information was provided. 3. Initially, the facility did not provide evidence of a comprehensive background check for Staff #8. However, at 4:10 p.m., the CEO presented a criminal background check that indicated that she had been charged with "Assault-first degree" and "Assault-second degree" in Prince Georges County Maryland. The date(s) that the charges were filed, and the status/outcome of the charges were not indicated. The report documented that the background check had been performed on 7/14/10 at 10:14 a.m. Shortly thereafter, at 4:35 p.m., Staff #8 was placed on administrative leave,

Health Regulation Administration

pending further investigation.

Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PRDVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING HFD03-0202 07/15/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **WESTVIEW 02** WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) Continued From page 2 {R 125} {R 125} This is a repeat deficiency. Previously, the 6/10/10 deficiency report included the following: 1. The 6/9/10 review revealed that a background check had been performed for Staff #1 (hired by the former management) in Washington, DC on 2/18/10. Her employment history, however, was not available for verification. No additional information was presented before the survey ended at 3:45 p.m. on 6/10/10. 2. The 6/9/10 review revealed that a background check that covered Maryland, Washington, DC and Virginia had been performed for Staff #2 (hired by the former management) on 9/8/09. Her employment history, however, was not available for verification. No additional information was presented before the survey ended at 3:45 p.m. on 6/10/10. 3. The 6/9/10 review revealed that a background check had been performed for Staff #3 in Washington, DC on 1/13/10. Review of her employment history on 6/10/10 revealed that she had worked in Silver Spring, Maryland from 10/04 - 8/05. Prior to 10/04 (but dates not specified). she had worked in Bladensburg, Maryland. There was no evidence of a background check that covered those jurisdictions. 4. The 6/9/10 review revealed that background checks had been performed for Staff #4 in Washington, DC and Maryland, on 7/2/09 and 2/2/10, respectively. However, review of her

employment history on 6/10/10 revealed that she

Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 07/15/2010 HFD03-0202 STREET ADDRESS, CITY, STATE, ZIP CDDE NAME OF PROVIDER OR SUPPLIER 74 'W' ST. NW **WESTVIEW 02** WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) (R 125) {R 125} Continued From page 3 had worked in Falls Church, Virginia in 09, and had worked in Danville, Pennsylvania from 5/06 -8/06. There was no evidence of a background check that covered those jurisdictions. 5. The 6/9/10 review revealed that a background check had been performed for Staff #7 in Washington, DC on 1/12/10. Review of his employment history on 6/10/10 revealed that he had worked in Baton Rouge, Louisiana from 1993 - 5/07. There was no evidence, however, of a background check that covered that jurisdiction. 6. The 6/9/10 review revealed that a background check had been performed for Staff #8 in Washington, DC on 3/31/09. Review of his employment history on 6/10/10 revealed that he had worked in Takoma Park, Maryland from 6/02 - 2005. There was no evidence however, of a background check that covered that jurisdiction. Prior to that, the deficiency report dated 5/3/10. included the following: Of the four newly hired staff, two of the criminal background checks failed to reflect a search was conducted in all areas where they either worked or lived over the past seven years as evidenced below: 1. Record review on 4/29/10, at approximately 12:20 p.m., revealed, Staff #2's job application listed him as either having worked or lived in the states of West Virginia and Pennsylvania within the past seven years. The criminal background check on record at the time of survey only covered the states of Maryland, Virginia and the District of Columbia.

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING 07/15/2010 HFD03-0202 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 74 'W' ST, NW **WESTVIEW 02** WASHINGTON, DC 20015 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {R 125} Continued From page 4 {R 125} 2. Record review on 4/29/10, at approximately 12:25 p.m., reveated, Staff #3's job application listed him as either having worked or lived in the state of Florida within the past seven years. The criminal background check on record at the time of survey only covered the District of Columbia.

Health Regulation Administration

Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PRDVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING HFD03-0202 07/15/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 74 'W' ST, NW **WESTVIEW 02** WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {1 000} {| 000} INITIAL COMMENTS A second follow-up survey was conducted on 7/13/10 - 7/15/10 to verify that the facility had come into compliance with deficiencies identified in the previous follow-up survey on 6/10/10. The governing body submitted a Plan of Correction dated 7/12/10. The follow-up visit revealed that there had been significant progress made since the 6/10/10 follow-up survey. However, through observation, interviews with staff and residents and review of records, the determination was made that the facility remained not in compliance with 22 DC Municipal Regulations, Chapter 35, Group Homes for Persons with Mental Retardation, as evidenced in the report that follows. $\{1.180\}$ (i 180) 3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, staff interview, and record review, the group home for persons with mental retardation (GHMRP) failed to ensure the qualified mental retardation professional (QMRP) coordinated, integrated, and monitored services, for five of the five residents residing in the facility. (Residents #1, #2, #3, #4 and #5) The findings include: 1. see W 159 #1 8/18/2D10 Cross-refer to Federal Deficiency Report -Citations W189 and W249) The QMRP failed to ensure that all direct support staff received training on consistent implementation of

Health Regulation Administration

TITLE

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(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 07/15/2010 HFD03-0202 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 74 'W' ST. NW **WESTVIEW 02** WASHINGTON, DC 20015 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ŧΩ (X4) ID PREFIX COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {1 180} Continued From page 1 {I 180} residents' behavior support plans. According to the QMRP, all five residents had behavior support plans. 2. [Cross-refer to Federal Deficiency Report -8/18/2010 See W 159 #2 Citations W189 and W252] The QMRP failed to ensure that all direct support staff received training on consistent and accurate documentation of behavioral incidents. 8/18/2010 See W 159 #2a 3. [Cross-refer to Federal Deficiency Report -Citation W192] The QMRP failed to ensure that direct support staff who were assigned to meal preparation duties were effectively trained on provision of Resident #3's prescribed high fiber diet. 4. There was no evidence that the QMRP had 8/18/2010 See W 159 #4 followed-up on the nutritionist's recommendation (4/29/10) to obtain a speech-language screening for Resident #3. On 7/13/10, interview with the Director of Nursing by telephone revealed that the facility had just entered into a contract/agreement with a speech/language therapist on the day before (7/12/10). She further indicated that to date. Resident #3 had not received a speech-language screening. This was verified through review of Resident #3's record on 7/14/10. This is a repeat deficiency. Previously, the 6/10/10 deficiency report included the following: 2. [Cross-refer to Federal Deficiency Report -Citations W189.1 and W252] The QMRP failed to

Health Regulation Administration

Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A RUILDING B. WING 07/15/2010 HFD03-0202 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 74 'W' ST. NW **WESTVIEW 02** WASHINGTON, DC 20015 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {| 180} {| 180} | Continued From page 2 8/18/2010 2. See W 159 #2 ensure that direct support staff received training on consistent and accurate documentation of behavioral incidents. 6. [Cross-refer to Federal Deficiency Report -6. See W 159 #4 Citation W460.2] There was no evidence that the 8/18/2010 QMRP had followed-up on the nutritionist's recommendation (4/29/10) to obtain a speech-language screening for Resident #3. Citation W460 in the federal deficiency report dated 5/3/10, included the following: "According to the <nutritionist's 4/29/10> assessment, the resident was 'having difficulty swallowing regular consistency. Individual holds food in mouth, takes a very long time Swallowing. Individual will be able to tolerate a mechanical soft diet. Will notify SLP (speech and language) for screening.' At the time of the survey, however, the SLP screening had not been scheduled." On 6/9/10, at approximately 3:15 p.m., interview with the QMRP revealed that she had not contacted the speech-language therapist (SLP) since she began serving as the QMRP on 5/14/10. She indicated that the facility's executive director planned to call the SLP to schedule appointments. She further indicated that the SLP "has to come. We're going to get everyone an assessment...all of them are outdated." On 6/9/10, at approximately 5:10 p.m., a direct support staff was observed in the kitchen. chopping food with a knife. When asked she stated that she and other staff always chopped Resident #3's foods to help his swallowing. However, review of the resident's physician's orders failed to show evidence that the recently-assigned PCP had been made aware of

the previous recommendations for altered food

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Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 07/15/2010 HFD03-0202 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 74 'W' ST, NW **WESTVIEW 02** WASHINGTON, DC 20015 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) (I 180) Continued From page 3 {| 180} texture and an SLP screening. On 5/19/10, the PCP wrote the following dietary orders: "Regular, Double portions, High Fiber snacks. Prune juice 1 cup twice daily." [It should be noted that on 6/2/10, a new nutritionist wrote "<Resident #3> was assessed for a complete nutrition evaluation...The current diet of mechanical soft texture is synonymous to a ground diet ... < Resident #3> should receive a ground texture."] This is a repeat deficiency. Previously, the federal deficiency report dated 5/3/10, included the following: 1. The facility's QMRP failed to ensure consistent 8/18/2010 documentation of progress on the Individual See W 159 #1a Program Plan (IPP) objective for Residents #3 and #4. [See Federal Deficiency Report - Citation W252] 2. The facility's QMRP failed to coordinate See W 159 #2a 8/18/2010 services to ensure menus were modified as necessary to provide the prescribed diet of Resident #3. [See Federal Deficiency Report -Citation W4601 {| 222} (1222) 3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: I. Based on observation, staff interview and record review, the group home for persons with

Health Regulation Administration

mental retardation (GHMRP) failed to ensure

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Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING **B. WING** 07/15/2010 HFD03-0202 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 74 'W' ST, NW **WESTVIEW 02** WASHINGTON DC 20015 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES 1D (X4) ID COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) Continued From page 4 { | 222} {| 222} staff was effectively trained on implementing residents' behavior support plans and documenting targeted maladaptive behaviors in the residents' behavior data, for 6 of the 13 direct support staff in the facility. The findings include: A. [Cross-refer to W249 and W252] On 7/14/10, See W 159 #2 8/18/2010 at 5:45 p.m., Resident #3 was observed standing in the living room without a shirt. His jeans were unbuttoned and unzipped. His boxer briefs were exposed. Initially, the resident was standing alone. However, a direct support staff person. began speaking with him from the nearby dining room. The staff did not encourage him to button up and/or zipper his jeans while they conversed. On 7/15/10 at 3:35 p.m., review of Resident #3's behavior data forms revealed that staff had not documented the 5:45 p.m. episode from the previous evening as required by Resident #3's behavior support plan (BSP) dated 4/19/10. Moments later, at 3:40 p.m., the qualified mental retardation professional stated that "staff should direct him to zip his pants up, if he refuses then staff would do it for him." The staff had not, however, been observed implementing the intervention strategies as outlined in the BSP. The facility documented having provided training on residents' programs and data collection on 7/9/10 and 7/13/10. Staff in-service training records were reviewed on 7/14/10. At 11:55 a.m., review of the staff signature sheets revealed that the male staff person who failed to instruct and/or assist Resident #3 with zipping his zipper (later that afternoon, at 5:45 p.m.) had received training on the previous evening

Health Regulation Administration

(7/13/10). There was no evidence that the

Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 07/15/2010 HFD03-0202 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 74 'W' ST, NW **WESTVIEW 02** WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {| 222} {| 222} Continued From page 5 training presented on resident programs and data collection had been effective. B. In addition, further review of the 7/9/10 and 7/13/10 signature sheets revealed that 7 of the 13 direct support staff had attended the trainings. There was no evidence, however, that the other 6 staff had received training on resident programs and data collection. II. Based on observation, interview, and record review, the facility failed to ensure that all staff were effectively trained to implement prescribed diets, for 3 of the 13 direct support staff in the facility. The finding includes: [Cross-refer to Federal Deficiency Report -See W 159 #2a 8/18/2010 Citation W460] On 7/13/10, at approximately 5:15 p.m., interview with the direct support staff person who was preparing dinner in the kitchen revealed that all 5 residents, including Resident #3, had received apple sauce for snack. Moments later, review of a list of "low fiber" foods that was posted on a kitchen bulleting board revealed that apple sauce was among the food items considered "low fiber." There was no comparable list of "high fiber" food items posted in the kitchen. Resident #3, who had already finished his apple sauce at the time, had physician's orders that prescribed an "increased fiber" diet. The staff person had prepared stir-fried vegetables with chopped turkey meat, to be served over white rice. When asked about Resident #3's prescribed high fiber diet and how the facility ensures that his meals are high in fiber, the staff person indicated that she wasn't

sure and then referred this surveyor to two other

Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 07/15/2010 HFD03-0202 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 74 W ST. NW **WESTVIEW 02** WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY {1 222} {| 222} Continued From page 6 (male) staff who had been "working here longer." Review of the menu she had used for that evening's meal revealed that it did not address high fiber diet plans. Staff in-service training records were reviewed on 7/14/10. The facility documented that on 6/14/10, the nutritionist presented training on prescribed diets. At 1:30 p.m., review of the 6/14/10 signature sheet revealed that the staff person who prepared the 7/13/10 dinner (and who was interviewed) was one of three current staff who did not attend the nutrition training. Only one of the two male co-workers she had mentioned by name had attended the training. In addition, review of the training materials used on 6/14/10 revealed a list of high fiber foods that recommended brown rice for increased fiber. On 7/13/10, however, Resident #3's stir-fry was served over white rice. This is a repeat deficiency. Previously, the 6/10/10 deficiency report included the following: 1. See W 159 #2 1. [Cross-refer to Federal Deficiency Report -8/18/2010 Citation W252] On 6/9/10, at approximately 8:15 a.m., Resident #3 was observed to remove all of his clothing while standing in the living room. Review of his records the next day, at 8:55 a.m., revealed that the staff who were on duty at the time failed to document the incident in on his behavior data sheets. Another behavioral incident was indicated in a staff log entry on 6/6/10; however, it too had not been documented

Health Regulation Administration

in the program book, in accordance with the

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Health Regulation Administration (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING B. WING 07/15/2010 HFD03-0202 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 74 'W' ST, NW WASHINGTON, DC 20015 **WESTVIEW 02** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)1D (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) $\{1222\}$ {| 222}, Continued From page 7 resident's behavior support plan (BSP), dated 4/19/10. On 6/9/10, at approximately 3:15 p.m., interview with the qualified mental retardation professional (QMRP) revealed that the facility had not provided in-service training since new management was appointed by a court on 5/14/10. This was corroborated a short time later (4:05 p.m.) by two direct support staff who were interviewed. 4. [Cross-refer to Federal Deficiency Report -8/18/2010 See W 159 #2a Citation W460] On 6/9/10, at 4:16 p.m., Resident #3 was offered sugar wafers for afternoon snack. The nutritionist, however, had recommended that he receive hi-fiber snack items, in part to address recurrent bouts of constipation and fecal impactions. Interview with the direct support staff on 6/9/10, at approximately 5:10 p.m., revealed that she was previously unaware of the recommended hi-fiber snacks. She stated that she had not received any training on diet plans and snack choices. She further indicated that there was no list of hi-fiber snacks available for staff reference. On 6/9/10, beginning at 3:11 p.m., the qualified mental retardation professional (QMRP) stated that the facility had not provided staff in-service training since the new management team was appointed on 5/14/10. This was also verified through review of training records on 6/10/10, at approximately 1:00 p.m. [Note: On 6/10/10, at 2:50 p.m., the QMRP pointed to announcements posted in the facility, for mandatory staff training by the nutritionist. It was scheduled for 6/14/10.]

Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 07/15/2010 HFD03-0202 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 74 'W' ST. NW **WESTVIEW 02** WASHINGTON, DC 20015 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {1 227} {| 227} Continued From page 8 {1 227} (1227) 3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: All staff who do not have their CPR and (d) Emergency procedures including first aid, 8/11/2010 first aid certification will be removed from the cardiopulmonary resuscitation (OPR), the schedule until they provide a current certifica-Heimlich maneuver, disaster plans and fire tion. evacuation plans; This Statute is not met as evidenced by: Based on record review and staff interview, the group home for persons with mental retardation (GHMRP) failed to ensure all staff completed training in performing first aid and cardiopulmonary resuscitation (CPR), for 3 of 4 staff whose training status was reviewed. (Staff #1, #2 and #4) The finding includes: The 6/10/10 survey had identified four staff (S1, S2, S4 and S7) as not having current CPR certification and first aid training. Review of personnel records on 7/14/10, beginning at 11:30 a.m., revealed no evidence that staff S1, S2 and S4 had received CPR certification and first aid training and since the 6/10/10 survey. [Note: Staff #7 was no longer employed by the facility.] Review of the staff in-service training records revealed that CPR and first aid training had been conducted on 7/9/10. When asked about S1, S2 and S4, the qualified mental retardation professional acknowledged that the 3 staff in question still remained without CPR certification and first aid training. However, she then presented a memorandum showing that those 3 staff were registered for the next training, which

was scheduled for 7/25/10.

Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING HFD03-0202 07/15/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 74 'W' ST. NW **WESTVIEW 02** WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) {| 227} {| 227} : Continued From page 9 This is a repeat deficiency. On 6/10/10, beginning at 12:37 p.m., review of personnel records revealed no evidence that staff S1, S2, S4 and S7 had current CPR certification and First Aid training. It should be noted that S1 and S2 had been employed by the former residence manager, while S4 and S7 had been employed by the new management, prior to their receivership appointment by a court on 5/14/10. The CEO/administrator acknowledged that some staffs' certifications had expired. He further indicated, however, that the next training had been scheduled for July 2010. This is a repeat deficiency. Previously, the licensure deficiency report dated 5/3/10 included the following: Interview with the facility 's House Manager (HM) on 4/29/10, at approximately 12:10 p.m., revealed the facility has hired four new staff since 12/09. Record review on the same day at approximately 12:55 p.m. revealed, none of the four staff records reviewed showed evidence of either first aid or CPR training. The GHMRP failed to ensure all staff received training in the areas of implementing First Aid or CPR as required by this section. 8/18/2010 (I 401) 3520.3 PROFESSION SERVICES: GENERAL {| 401} See W 159 #4

Health Regulation Administration

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Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING 07/15/2010 HFD03-0202 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 74 'W' ST, NW **WESTVIEW 02** WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5)(X4) 1D COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY)** {| 401} {1 401} Continued From page 10 Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview, and record review, the group home for persons with mental retardation (GHMRP) failed to ensure professional services included timely diagnostic. evaluation, and treatment services to prevent deterioration or further loss of functioning, for one of the five sampled residents. (Resident #3) The finding includes: There was no evidence that the GHMRP followed-up on the nutritionist's recommendation (4/29/10) to obtain a speech-language screening for Resident #3. On 7/13/10, interview with the Director of Nursing by telephone revealed that the facility had just entered into a contract/agreement with a speech/language therapist on the day before (7/12/10). She further indicated that to date. Resident #3 had not received a speech-language screening. This was verified through review of Resident #3's record on 7/14/10. This is a repeat deficiency. Previously, the 6/10/10 deficiency report included the following: Based on observation, interview and record

Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING HFD03-0202 07/15/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **WESTVIEW 02** WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {I 401} Continued From page 11 {| 401} review, the facility failed to address the nutritionist's recommendation (4/29/10) to obtain a speech-language screening for Resident #3, as follows: Citation W460 in the Federal Deficiency Report dated 5/3/10, included the following: "According to the <nutritionist's 4/29/10> assessment, the resident was 'having difficulty swallowing regular consistency. Individual holds food in mouth, takes a very long time swallowing. Individual will be able to tolerate a mechanical soft diet. Will notify SLP (speech and language) for screening.' At the time of the survey, however, the SLP screening had not been scheduled." On 6/9/10, at approximately 3:15 p.m., interview with the QMRP revealed that she had not contacted the speech-language therapist (SLP) since she began serving as the QMRP on 5/14/10. She indicated that the facility's executive director planned to call the SLP to schedule appointments. She further indicated that the SLP "has to come. We're going to get everyone an assessment, all of them are outdated." On 6/9/10 at approximately 5:10 p.m., a direct support staff was observed in the kitchen. chopping food with a knife. When asked, she stated that she and other staff always chopped Resident #3's foods to help his swallowing. However, review of the resident's physician's orders failed to show evidence that the recently-assigned PCP had been made aware of the previous recommendations for altered food texture and an SLP screening. On 5/19/10, the PCP wrote the following dietary orders: "Regular, Double portions, High Fiber snacks. Prune juice 1 cup twice daily."

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING HFD03-0202 07/15/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 74 'W' ST. NW **WESTVIEW 02** WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) {| 401} {I 401} Continued From page 12 It should be noted that on 6/2/10, a new nutritionist wrote "<Resident #3> was assessed for a complete nutrition evaluation...The current diet of mechanical soft texture is synonymous to a ground diet ... < Resident #3> should receive a ground texture."] 8/18/2010 1422 1422 3521.3 HABILITATION AND TRAINING See W 159 #1 Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, facility staff failed to consistently implement resident behavior support plans, for one of the five residents included in the sample. (Resident #3) The finding includes: Observation on 7/14/2010 at 5:45 p.m., Resident #3 was observed standing in the living room without a shirt. His jeans were unbuttoned and unzipped. His boxer briefs were exposed. Initially, the resident was standing alone. However, a direct support staff person began speaking with him from the nearby dining room. The staff did not encourage him to button up and/or zipper his jeans while they conversed. On 7/14/2010, at 9:35 a.m., review of Resident #3's behavior support plan (BSP) dated 4/19/10, had revealed "Disrobing" or "removing clothes not in the bathroom/bedroom" was one of several challenging maladaptive behaviors identified in the BSP. In an interview with the qualified mental

Health Regulation Administration

Health Regulation Administration

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